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Topeka Kansas

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ARKANSAS'S MENTAL HEALTH PLAN*

By SIDNEY S. McMATH†

Note: It is typical of the exemplary cooperation of federal, state and city agencies practiced in Little Rock, Arkansas, that an outstanding neuropsychiatric meeting is conducted each year at the Veterans Administration Hospital which is participated in by representatives of all of these agencies as well as by many invited guests. The address of Governor McMath, which we are proud to reproduce here, impressed some colleagues, including one of the editors, as one of the best statements of a psychiatric hospital program ever to come from a public official. Governor McMath clearly aligns himself here with the progressive goals of Governor Luther Youngdahl of Minnesota, Governor Frank Carlson of Kansas, and an increasing number of other wise and alert governors.

The Editors

It is indeed unfortunate that fear and prejudice have for so long hidden the true scope of this nation's mental health problem from its citizens, for these factors have long prevented our mentally ill from receiving the care and treatment that they have needed. I can see no reason to let these unfortunate happenings of the past retard us in the future handling of this problem, for although we still see the clouding influence of prejudice and superstition, the issues involved have now become clear and we can attack them both openly and effectively.

With the foregoing facts in mind, we in Arkansas have embarked on what we feel to be a sound mental health program. This entire program is based on the premise that Arkansas is, on a per capita basis, a poor state and that if we are to improve our overall socio-economic conditions, we must not only develop and conserve our natural resources, but protect and develop our human resources as well. Certainly we can do neither if we neglect the mental health of our people, for mental disease is a costly disease both from the cultural and the economic standpoint and its

* Presented at the Neuropsychiatric Meeting, Veterans Administration Hospital, North Little Rock, Arkansas, Feb. 24, 1950.

† Governor of Arkansas.

inroads into community and family welfare can at times be totally disastrous to the economy of the group.

We have undertaken the job of surveying the mental health problem in our state with the idea of analyzing the facts involved, so that we may begin taking steps to prevent or treat mental illness properly. This survey, which consists of a detailed analysis and follow-up study on some 32,000 former patients of our state hospital system, has been in progress approximately one year. From the survey, although it is yet in its infancy, we are already able to determine to a fairly accurate degree what our future hospital loads will be, where our centers of potential patient density are, and where we should locate our mental hygiene clinics and hospitals. This is, of course, only a portion of the facts being obtained from this survey, but these are the ones of immediate interest in our present planning.

As our survey has progressed, we have been able to verify an obvious fact, namely that we are in immediate need of additional hospital facilities. However, we have also found that there would be little use in building such facilities if there are no trained people to operate them. Having, in the past, made this rather awkward mistake far too often, we do not intend to repeat it again. To prevent such a situation, we have asked that adequate training facilities be developed in our state hospital, university, and medical school, to insure the production of properly trained professional personnel to meet the mental health needs of our citizens. We have indeed been fortunate in this objective, for the Little Rock Veterans Hospital has already done much toward furnishing a nucleus of trained psychiatrists with which to start this program, and it has done much to impress upon the people of our state the advantages of such specialized training for professional personnel. Many of our local physicians have received their psychiatric training in the residency program of this hospital and virtually every student nurse graduated in Arkansas during the past three years has received three months special training in this institution.

In addition to these factors, this hospital has, with the aid of our state hospital and our psychiatrists in private practice, established a department of neuropsychiatry in our state medical school which offers training in this field to all medical students during each of their four years of schooling. With this rather auspicious beginning, we have developed and requested approval for a residency training program in our own state hospital and will begin training psychiatrists as soon as this program is approved.

However, we realize that even after we begin to train psychiatrists, we will never be able to produce enough to meet the demand; therefore we have taken as our training goal the development of a well qualified and well trained "psychiatric team." This team, which will be composed of a psychiatrist, a clinical psychologist, a psychiatric social worker, a psychi-

atric nurse, a number of psychiatric technicians, and a few psychiatric aides, will be so oriented and so organized that it can handle a large number of patients inside mental hospitals or in mental hygiene clinics, and will be able to form cadre units to staff newly developed facilities.

At the present time, the Arkansas State Hospital is offering a three year training course to qualified psychiatric aides who wish to become psychiatric technicians, and is working with our state university in establishing training programs in clinical psychology and sociology. Unfortunately, the training of nurses must wait until we complete our new medical center, for we do not have the facilities at this time to offer advanced training to this group of individuals. We do, however, hope to have virtually all our training programs in operation by the end of 1950, or early in 1951.

As it would be unwise to build hospitals for our mentally ill without training professional personnel to staff them, it would also be unwise to train these people and then force them to attempt to treat patients in antiquated, over-crowded facilities. With this in mind, we asked some time ago that steps be taken to develop plans for a new 1500-bed diagnostic, training and acute intensive treatment center to replace the present mental hospital at Little Rock. This unit, which will be located immediately adjacent to our new, modern medical center and medical school, will work closely with this portion of the university so that, through mutual aid and support, these two institutions will be able to render the best possible care to the physically and mentally ill citizens of our state. We hope that through this arrangement, our medical students will be able to receive a wider training in the field of psychiatry, and that our resident physicians at both the hospital and medical school will be able to obtain an opportunity to acquaint themselves with other fields within their profession. However, we feel that if we gain no more from this move than better psychiatric training for our young doctors who must go out into the rural areas of our state, we have indeed done a great deal, for the general practitioner is still the backbone of medicine in Arkansas, and these physicians can do much toward helping to solve the mental health problem of our people.

In discussing our mental health plans, I have purposely left until last possibly one of our most pressing problems. That problem, of course, is what to do with our ever increasing number of people over 65 years of age who are seeking admission to mental hospitals. At the present time, we have hospitalized in our state mental institutions, some 1100 patients who suffer from the degenerative effects of age. Many of these individuals, in fact well over half of them, suffer from no more startling symptoms than those commonly seen in our own aged parents. However, due to their lack of funds, shortage of housing and, in some cases because they are merely in

the way, they must seek shelter in our state mental institution. Certainly this is not a proper solution to the problem, for these older people, by the sheer weight of their mass, are prohibiting the treatment of patients who might otherwise benefit from mental hopsital care if there were beds available to them. Yet our aged must have somewhere to go even though it means being locked up in the restricted environs of a mental hospital to wait out their remaining days. It is unfortunate indeed that we, the citizens of Arkansas, like the citizens in other states, have either failed to see this problem developing or have failed to appreciate its true size and scope, for we are now faced with the problem of caring for thousands of our aged within facilities that were built for other purposes. In other words, we have sat idly by, watching longevity being added to living and yet we have been doing nothing to add living to longevity.

Our research studies dealing with the aged in this state show definitely that we are only seeing the early stages of this problem, and that we will not only have more and more aged in our population group but larger and larger numbers of these individuals seeking state or government care. I have asked that our educational, welfare, and hospital people take immediate steps to develop suitable plans for caring for these individuals. We have already raised the amount of funds paid to the aged under our welfare acts and have augmented this by giving vocational training in crafts and other forms of rehabilitation to our older individuals, in order that some of them may be able, through their welfare aid and a limited amount of self-support, to live a fairly happy existence in the twilight of their lives.

I have also recently appointed a committee to study the nursing home and hospital needs of these older citizens and have asked this committee to report to me at the earliest possible date, their findings and recommendations in this matter. As soon as this report becomes available, we will immediately begin to take steps to create proper institutions for the care and treatment of these individuals.

In conclusion, I should like to state that I have closely studied the various ramifications of the mental health problem in this state and I feel that I can safely say that we will be able to solve it both efficiently and effectively in the very near future. The reason for my optimism lies in the fact that in Arkansas we have among our state and federal mental hospitals, our university, and private psychiatrists, a spirit of cooperation and teamwork that is rarely seen in professional circles. Certainly with all these groups working together in a common cause, we should have little to fear from this problem in the future.

MALINGERED PSYCHOSES*

By HENRY A. DAVIDSON, M.D.†

Because the psychiatrist has been trained to take a patient-loving attitude, it is difficult for him to consider the possibility of deliberate fraud. Indeed, there is even a strange thesis that malingered psychosis is impossible. This doctrine derives from the following premise: no one in his right mind wants to be considered psychotic. Therefore, if a person wilfully pretends to be psychotic, he is not in his right mind. Q.E.D. This is somewhat naive. A defendant in a criminal case, faced with the near-certainty of being hanged, would be very sane and sensible in trying to escape with commitment to a mental hospital. In *operational* terms, a sane man might, and sometimes does, pretend to be psychotic in order to escape conviction. Whether, in *dynamic* terms, this is consistent with "normal" behavior is another question. This distinction between an operational and a psychodynamic concept seems to me valid in the sense that the psychiatrist, in order to be of any practical use in the administration of criminal justice must use operational concepts. He must conform to the current concepts of criminal responsibility when he is examining and testifying. He can crusade for a broader concept from the lecture platform or through the medical journal. But in the witness box, he either accepts the semantic straightjacket imposed by juridical thinking or he is quite literally ruled out of court, and his usefulness terminates.

For example: it may be contended that criminal behavior is always evidence of a deep-seated emotional disturbance; in other words, it is theoretically possible to contend that all criminals have psychiatric disorders, that they are all products of their environment and their heredity, and that therefore no criminal is ever responsible. Such a thesis could be logically defended in the light of modern psychiatric thinking. But in an actual case, a psychiatrist who took that position would be ignored by the jury. The judge would tell the jury that that is not the law. The prosecutor would say that if this expert's testimony were accepted, our entire judicial machine would grind to a stand-still, courts would become clinics, and prisons would become hospitals. To the psychiatrist this might not sound like a bad idea. But society is not ready for any such concept. The doctor who expects to operate within the framework of our judicial system cannot function there if he espouses the doctrine of universal irresponsibility.

* Condensed from a talk before the Menninger Foundation School of Psychiatry at the Winter Veterans Administration Hospital, Topeka, Kansas, September 15, 1949.

† Flemington, New Jersey.

Thus, his psychodynamic concept of crime would clash with the current operational concept.

A similar conflict is noted with respect to the doctrine of "knowing that the crime was wrong." If a defendant acts as if he knew he was doing wrong, he is considered responsible. That he may *say* that he was doing a righteous thing, or that he may *think* he was but carrying out God's instructions, would mean nothing if he tried to conjure a false alibi, rubbed out his finger-prints or otherwise *acted* as if he knew he was doing wrong. Here too, we must use an "operational" concept. The test in day by day court proceedings is "how did the defendant operate," not "how did he think."

Malingering presents the same distinction. Thus, while crossing the Pacific on an army transport, a colleague said to me: "I shall try New Guinea for a few weeks. If I don't like it, I'll get a backache. That will be my story and I'll stick to it until they return me to California." A few months after arrival he reported to sick call with a backache, and after several hospitalizations, he was evacuated. It may be argued that a person with a normal and wholesome personality would not have done this. Dynamically this is true. But he acted (that is, he "operated") as if he were perpetrating a deliberate fraud. Within the framework of "pure psychiatry" he would be labeled with a psychiatric diagnosis. But if we use "operational" terms, we would have to call him a malingerer.

Surprisingly few defendants in murder cases enter a plea of irresponsibility. Since many of these defendants have only a forlorn hope of acquittal, this hesitancy in alleging "insanity" seems illogical. One must conclude that there is some powerful drive within us which keeps us from "acting insane." And conversely, it must be concluded, that the defendant who deliberately pretends to be psychotic is already suffering from some kind of psychiatric morbidity. In fact, I believe that there is even such a thing as the malingering of malingering. I once examined a soldier who, while on guard duty, aimed his rifle at his own head and pulled the trigger. The gun jammed, and the ordnance experts told us that this was due to an unpredictable defect in the rifle mechanism. The attempted suicide was apparently bona fide. The soldier seemed depressed, and I recommended his return to the states because of a reactive depression. He was discharged from the Army and in his first letter thereafter he told his former colleagues that he had pretended to be depressed, and that actually he had "put something over" on the board of psychiatrists. He was now earning a good wage in a war plant, and his letter mocked his former colleagues who were still in the South Pacific, while he boasted of his financial, sexual and social conquests in the United States. His next letter hinted that he had uncovered a spy plot in the factory, and thereafter his mail showed

evidences of continuing paranoid thinking until, by time the last letter arrived, it was obvious that he was psychotic. It seems clear now, that his first letter represented a malingering of malingering.

In spite of this, however, it must not be assumed that malingering is non-existent. It is still true that a person may deliberately pretend to be psychotic, and it is this possibility which sets a two-way trap for the psychiatric examiner. If he labels the defendant a malingerer, and he later turns out to be psychotic, the doctor has failed in one of the primary duties of the psychiatrist: to recognize a psychosis when he sees one. If he places the stamp of genuineness on a deliberate malingerer (even though the defendant is a "psychopath") he damages his own reputation for acumen, impairs his usefulness to the courts, and helps a criminal get away with murder.

The sophisticated examiner considers the possibility of malingering in every major criminal case. Even the most expert psychiatrist will fall into error now and then. Criticism will come not from making an occasional wrong diagnosis, but from being blind to all the diagnostic possibilities. The first step in recognizing a malingered psychosis is to consider seriously that it is possible. For some of us, this first step is the hardest.

The courts sometimes assume that there is a sort of "sanity test" in the doctor's bag—some gadget that can be pulled out and applied to the defendant. For this reason, some judges and prosecutors expect the psychiatrist to walk into the case without preliminary briefing and to give an opinion without having the patient's personal history. Only an inexperienced examiner allows himself to submit a report based on a single interview without history. Except in the most obvious cases, the mature psychiatrist will insist on having the patient's past history made available—and will suspend judgment until he has looked at the record.

The third step is to make a clinical diagnosis of the apparent psychosis. Does this seem too obvious to be listed here? Sometimes when effort is made to fit the clinical symptoms into a recognizable diagnostic category, it cannot be done. And that alone may point the way to an ultimate determination of malingering. It is easy enough to note a set of delusions or hallucinations and to attach a label like "psychosis, unclassified." Suppose a defendant is exhibiting obvious and fantastic delusions of grandeur. An examiner might conclude that only a psychotic would be so delusional and let it go at that. The more careful psychiatrist will wonder whether this is the grandeur of the schizophrenic, the paretic or the manic. He tries to fit the total picture into one of these categories, and when he finds that it does not conform to any recognizable psychosis, his suspicions may, for the first time, be aroused.

Delusions

The nondeteriorated psychotic has learned that his delusions are not readily accepted; and unless very distressed, he does not gratuitously volunteer information about them. A malingerer finds it necessary to keep reminding the examiner of his delusions. Well organized delusional systems take time to develop. In the malingerer, the history will show that these delusions have developed with astonishing speed. In psychotics, a delusion is not an isolated symptom. The psychiatrist knows that "monomania" is only a journalistic artifact. The malingerer does not know this. A psychotic's behavior conforms to his delusions, unless he is deteriorated. To be sure, a schizophrenic may uncomplainingly mop the ward floor while asserting that he is a king or a god. But his total behavior is consistent—if not with his delusions, at least consistent with his schizophrenia. A victim of persecutory delusions acts as if he were persecuted. He who malingers a delusion of persecution may well conclude that he has done the job when he asserts the delusion. His behavior then, will not be that of a man harassed by persecution.

Depression

A patient in a genuine depression will, after a time, show physical signs of lowered metabolism. Temperature may even become subnormal. The hair and skin are often dry. Sometimes the red cell count falls below normal. The facies soon freeze into an aspect of worry or anxiety. The gait begins to change, and before long the patient walks with head and trunk flexed. The malingerer does not know this. Even if he does, he finds it almost impossible to sustain this picture hour after hour, day after day.

Mutism

Consistent mutism is at once the most difficult form of malingering to expose and the most difficult to maintain. If a defendant from the moment of his arrest, all through indictment, arraignment, confinement and trial, remains absolutely mute, no psychiatrist can demonstrate that this is malingered. Fortunately, this monolithic silence is almost unbearable to the sane man. It means that the defendant must sit in his cell or walk in the yard day after day, hearing statements about himself that cry out for contradiction, but saying nothing. He must deny himself the solace of companionship in his most trying period. He must spurn all offers of friendliness, eat only what is put before him, do without tobacco or any other little luxury that he might have by mumbling a brief request. Few sane persons are cast in so heroic a mould that they can do this sixty minutes an hour, twenty-four hours a day.

Excitement and Mania

It is practically impossible for a sane person to keep up the unrelenting overactivity of acute mania. Fatigue will prematurely terminate a spurious period of excitement. In true mania, the patient eventually becomes toxic, often feverish. His tongue coats, his pulse speeds up. The flight of ideas of mania has an idiomatic quality which is easy to recognize but hard to imitate.

Negativism

Since jailors will not let a prisoner starve, it is not difficult to refuse food. It is much less likely however, that a defendant will deliberately lie in his own feces. Yet this will occur in true negativism. There is also sometimes a behavior equivalent of the "Ganser" type of answer. Thus, asked to put out his tongue, the defendant might point to his ear; asked to lift his right hand, he might lift his left foot. These are "approximate answers" cognate to the verbal responses in the Ganser syndrome. There is simply no psychosis in which this kind of action-response is typical. A negativistic catatonic might shut his mouth firmly, when told to open it. He would hardly, however, in response to such a request rub his nose or scratch his ear. Waxy flexibility is difficult to maintain for any time; and the schizophrenic background should be available in the history.

Stereotypy

Sometimes a defendant thinks that a simple repetition of the same phrase or gesture is a touchstone of insanity. Verbal stereotypy does occur in depressions and in schizophrenia. But it is never the only symptom. Where the constant repetition of a phrase or movement is alone alleged to be evidence of a psychosis, the doctor will properly be suspicious of it.

Bizarre Behavior

Most laymen believe that the essence of insanity is a delusion of misidentification; in lay lore, the traditional psychotic is the patient who thinks he is Napoleon, a goat, or a poached egg on toast. This is why malingered psychosis so often takes on a clownish and bizarre quality that is seldom found behind the walls of state hospitals. In the court room, the defendant might walk like an ape, prance like a goat, or try to stand on his head. It is precisely the sort of thing a child might do when asked to illustrate his concept of queer behavior. Actually this kind of behavior is incredibly rare in true psychoses. When bizarre behavior is feigned, it is thrust on the examiner. In a true psychotic, it is only a casual by-product of the total psychosis. Exhibitionism is not characteristic of psychotics, and it is exhibitionistic clownishness which gives the malingerer the air

of "putting on a show." Contrary to lay opinion, the psychotic is not a buffoon. Buffoonery suggests a feigned psychosis.

The Ganser Syndrome

There is an easily recognized syndrome found in certain prisoners, known as "The Ganser Syndrome." The patient appears stupid or stupefied. He gives answers which are vaguely relevant to the query, but absurd in content. He might give the date as January the 45th, or—in answer to a question—tell you that he has fourteen fingers. Some authorities consider the Ganser syndrome to be an hysterical reaction. Perhaps it is; but it is certainly not a true psychosis. However some text books do include the Ganser syndrome under the rubric of psychoses. On the witness stand, the doctor who dismisses a Ganser syndrome as a form of malingering, may find himself in difficulties. The cross examining attorney *can* cite text books to support his contention that this syndrome is a psychosis. What the honest psychiatrist can say in such a situation, however is this: the reaction did not develop until *after* the crime was committed; the syndrome is a reaction to arrest and imprisonment; it did not exist before arrest and therefore throws little light on the defendant's mental state at the time the crime was committed. It is the result of the defendant's aggressive behavior, not the cause of it.

Amnesias

A common defense is: "Everything went black; I don't remember a thing." For this, there are six possible explanations: hysteria, psychosis, alcoholism, head injury, epilepsy and malingering.

The amnesia is not branded as spurious until each of the other five explanations has been considered and discarded. The report should show a negative skull X-ray. The head injury, if any, should not have been accompanied by a prolonged period of unconsciousness. The electro-encephalographic tracing must show neither a traumatic nor an epileptic pattern. The neurologic examination should be substantially negative. The life history should not suggest hysteria. The clinical examinations and clinical pictures should be inconsistent with alcoholism or psychosis. Hypnotism or interview under intravenous barbiturates will not identify malingered amnesia because in both hysterical and malingered amnesias, some recapture of memories will take place under narcosis or hypnotism. However, a malingered amnesia is generally patchy and self-serving. A genuine amnesia usually extends to all areas of memory and is not limited to facts which might hurt the defendant's "case." A patient with hysterical amnesia often forgets his name. Curiously enough, in malingered amnesia, the subject rarely alleges loss of his own identity. It is seldom necessary for

the medical witness to testify bluntly that the amnesia is spurious. All that is needed, legally, is testimony that, in spite of the present amnesia, the defendant, at the time of the crime, acted as if he knew he were doing something wrong.

Recognition of malingering is not made by using these suggestions as a mechanical check list. Not a single one of these differential points is absolute. The diagnosis comes from assembling into an integrated whole all these factors, each of which may be individually of little importance; but all of which, in the aggregate spell out a story that can be read plainly enough by the doctor who will take the trouble to look at the total picture steadily and look at it whole. It is, of course, a distasteful chore for the psychiatrist to brand a "patient" as a malingerer. In our patient-oriented philosophy, sympathy is admittedly a prime requisite. But softness of heart need not imply softness of head.

IDENTIFICATION: A CRUCIAL CONCEPT FOR SOCIOLOGY*

By LOUISA P. HOLT, Ph.D.†

What concern can sociology have, one might well ask, with such a strictly psychological phenomenon as identification? It will be the purpose of this paper to show, first, that the concept of identification is of fundamental significance for sociological theory as well as for psychoanalytic theory, and second, that the problem of identification has an important relationship to Freud's postulates about instinctual drives. No attempt will be made here to discuss either of these concepts in detail nor to examine the dynamic mechanisms of identification. It will be sufficient if we regard the latter process simply in terms of an emotional relationship involving the assumption by one person of behavior, attitudes or feelings expressed by other persons and if we view as instincts the pair of basic drives postulated by Freud: love (Eros) and aggression or destructiveness.

In considering the problem of identification, it may be fruitful to adopt a quasi-experimental approach. We can test the importance or discover the function of something by seeing what happens when that something is not there, just as we could by removing some part of an organism and seeing whether—or how—the organism survived without it. Let us therefore try to see what happens when sociological theories ignore the process of identification.

What are the main problems a sociologist has to try to understand? Most fundamentally, the sociologist wants to know what makes a society tick (a society or a less inclusive group within the larger whole); how it maintains itself, and realizes itself; how succeeding generations of individuals are fitted into it as functioning members, their activities coordinated in such a fashion that the society itself continues along its established way—with some modifications from time to time, of course, in response to the group's changed needs or altered situation. Take an assortment of newborn infants over, say, the past twenty years, from all over this country and some from other countries. What kind of miracle will be accomplished in the next thirty or so years to transform these babies, who don't know what it's all about, into members and candidates of a psychoanalytic society, all (or most of them) acting in such a way as to insure the continued existence and further "self-realization" of the society? It's a very basic and chal-

* Part of a longer paper read to the Topeka Psychoanalytic Society, Nov. 26, 1949. The writer wishes to acknowledge the support of a U. S. Public Health Service Postdoctorate Research Fellowship from the National Institute of Mental Health, which helped make possible the development of the ideas presented in this paper.

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lenging problem. Or what keeps the city of Topeka functioning through the decades, or the State of Kansas, or the U.S.A., or the Trobriand Island?

That is the kind of fundamental problem that sociologists—and anthropologists and other social scientists—try to tackle. How do you get all these individuals doing what they ought to in order to make their society function—obeying the rules, doing their jobs, reproducing themselves, accepting certain shared values, adapting to necessary changes. Also, what accounts for some of the failures in this orderly scheme of things—what are the sources of strain and disequilibrium in a society, why do some members not function in the ways that the society prescribes?

In the history of social science two principal kinds of answers have been given to this basic question of how individuals manage to function as members of a group or of a society. The first takes as its point of departure the assumption of a so-called "social contract." According to this notion, at some primeval period men decided that life would be pleasanter and more secure if they signed an agreement not to plunder from and kill each other any more; it was a rational decision, rationally executed. From that time forward, this theory held, people were guided by purely rational considerations to accept the dictum that crime doesn't pay; since only misfortune, isolation and misery issue from disobeying the terms of the contract (the rules governing society), people *have* obeyed, by and large. They do what they are supposed to do as members of society, and are more content by virtue of their obedience. They calculate the pleasures and the pains involved in various alternative courses of action, and naturally choose the pleasurable way.

This point of view is that of the "utilitarian" theorists of the last century; from their assumptions also sprang the doctrine of "make the punishment fit the crime"—make the painful consequences of law-breaking just enough greater than the gratifications to be gained by these infringements, and people will then be deterred from criminality and will choose rationally to be law-abiding citizens. And from the free pursuit by every individual of his own rationally conceived self-interest arises the harmonious functioning of society, based upon all individuals' "natural identity of interests." I might point out parenthetically that a hint of this utilitarian theorizing, with its basis in a hypothetical social contract, crept into one phase of Freud's[1] thinking about the origins of society, when he supposed that after killing the father of the primal horde the sons—the band of brothers—agreed to abide by the rule of exogamy. By reaching a decision to deny themselves access to the women made available to them by the murder of the primal father, they insured in rational fashion that strife among themselves would be minimized from that day henceforward.

There is a latter-day version of this first kind of approach, too, which

enjoys a considerable vogue at the present time. Its chief exponents are those who call themselves disciples of Clark Hull, at Yale—the "learning theorists," some of whom have also been irreverently labeled "diaper determinists." In brief, they hold that people, like rats, learn what they are rewarded for learning—learn to behave in ways that are rewarded, and learn not to behave in ways that are punished. Such writers as Geoffrey Gorer and Margaret Mead, to name only two of a rather rapidly increasing throng, tend to go along with this view. The child, they argue, learns to take his place in society, learns to assume certain roles and certain traits of personality, because these are rewarded by the adult members through their bestowal of love and approval. Meanwhile, non-conforming modes of behavior are correspondingly punished. The experiences by which the child learns which kinds of actions to perform or which qualities to display, and which to avoid, are held to be primarily connected with the "basic disciplines" imposed upon the child—swaddling, nursing, weaning, toilet training, indulgence or prohibition of sexual activities, and the like. A deviant, from this point of view, is simply a person who has been punished for the wrong things or not rewarded sufficiently for the right things. If he is properly conditioned, he "fits" into his society, and enough people are conditioned in the same way so that the society is maintained. It's all very nice and simple.*

These theories can, I believe, properly be grouped together under the heading of a rationalistic or utilitarian position, which holds that individuals become adequately functioning members of society because they find it useful or rewarding to do so. There is, to be sure, a distinction between them—the utilitarian theorists believed that human beings, since they are rational, reach thoughtful decisions about the actions they will undertake; the learning theorists feel that learning is of a more automatic

* An excellent critique of the self-styled "learning theorists" is to be found in an introductory contribution by Henry A. Murray[3] and Clyde Kluckhohn to their symposium, *Man in Nature, Society and Culture*. They point out, first, that these theorists neglect much of the differentiated patterning that is to be found in an organized social group, thus overemphasizing the uniformities that exist. Second, they fail to distinguish between the kind of learning accomplished by rats and that which is accomplished by the child—the latter must learn completely to suppress actions which would yield powerful gratifications, while the rat needs only to select one instead of another means for achieving gratification. Third, the learning theorists pay attention only to the "reduction of tension" (katabolic processes) and neglect the (anabolic) processes by which the store of tension is replenished or even increased. In trying to link their ideas with those of Freud, the learning theorists rejected his later hypotheses about the nature of instinctual drives—life and death instincts—and clung instead to his earlier conception of libido. I believe that these theorists' failure to grasp the import of Freud's later ideas is one reflection of the inadequacy of their own formulations.

character, that people are *conditioned* by the rewards and punishments, the gratifications and deprivations, that they have received, particularly during their earliest years. I want to lump the two kinds of theory together, for the sake of simplicity, and both can be called simply theories of "rational learning."

There is another, the second kind of approach I mentioned, which is in effect the antithesis of this first one. Adherents of the second point of view are not so much impressed by man's rationality; they hold that it is something non-rational, perhaps mystical, more likely biological, that impels individuals to function as members of groups. It may be a folk-spirit, or a herd instinct, or an inherited racial unconscious that is being manifested in people's organized social life, these theorists hold—something inherent in their genetic constitution, which is relatively unaffected by utilitarian considerations of mere gains or losses, pleasures or pains. Why should the true Aryan, for example, stoop to inconsequential considerations of profit or loss? What pettiness of spirit! It is in his blood to be a member of the master race, no matter what the cost! And according to this view, those who are deviant are racially inferior, atavistic specimens who exhibit an arrested stage of human constitutional development which they will in all likelihood pass on to their descendants. Again, the answer is simple, though perhaps not so nice. Unfortunately there is a suggestion of this approach also in Freud's thinking, for he held that it is the *biologically inherited* memory of the primal father's murder which accounts for the burden of guilt civilization has imposed ever since upon the members of human society.*

So far we have a dilemma. Either it is a matter of brute conditioning to pleasure and pain or of rational choice between pleasures and pains on the one hand, or it is something in the biological endowment, in the blood, in the instincts, or in the racial unconscious on the other hand, that can explain, for example, one's participation in the functions of a psychoanalytic society. There seems to be no way out of this dilemma; one can only shuttle back and forth between its two horns, or try to make an uneasy amalgamation of the two points of view. Query the advocates of

* It should be noted that in *Civilization and Its Discontents*, Freud[3] concluded it was not necessary to assume that the primeval murder had actually occurred and been unconsciously remembered by later generations. With the introduction of his hypothesis of the death instinct another explanation of man's persisting sense of guilt became possible: If every human being harbored innate aggressive impulses, these alone could give rise to sentiments of guilt and remorse; these likewise entered into the process of identification, and the existence of the primal horde was no longer an important issue. Later on, it is true, Freud[4] returned to his earlier hypothesis and reiterated his belief that the memory of this event must have been passed on through biological inheritance.

the second position a bit further and they'll admit that learning and experience have something to do with the way people behave; query the utilitarians further—ask them, for instance, how it comes about that man *is* a rational creature—and they'll be forced to say that it's something in man's biological endowment that makes him so.

I am convinced that the means of resolving this dilemma is by paying attention to the process of identification. Analysts become analysts, I think, more because of the particular sequences and patterns of identification they have gone through (or are currently going through) than because of rational calculations that the lot of an analyst is a happy one, or because of particular biological endowments or racial memories. It is the relationships we form to other people, the emotional attachments that influence so much of our feeling and thinking, that are crucial in determining our behavior as members of society. This is, indeed, the conclusion reached by Freud in *Civilization and Its Discontents*[3] and in *Group Psychology and the Analysis of the Ego.*[5]

Interestingly enough, this insight is not derived solely from psychoanalysis. An eminent French sociologist, Emile Durkheim,[7] working at the same period as Freud but independently of him, tackled the dilemma in sociological thinking that I have been trying to describe and surmounted it by concluding that it is through a process of identification that the child is gradually transformed into a functioning member of his society.* The first objects of this process are, for the child, his mother and father. Later on his teachers and other revered or ideal persons are, as it were, incorporated by the child and made a part of himself, his beliefs and conduct being patterned after theirs, at first rather indiscriminately, later in more selective fashion. The child does this, Durkheim states, because of his dependence upon these people, first for the simple satisfaction of his own vital needs, and later because he requires a sense of identity with other persons, of attachment to the group or the society, in order to feel that his own personality is integrated and complete. Neither one of these motives is, to be sure, a matter of rational calculation on his own part, nor is either one simply a matter of conditioning. Although Durkheim does not use the word "identification," he speaks of the individual's "attachment" to the society, the way in which society "penetrates" the individual who in his turn "incorporates" it, and he describes the child's irresistible tendency to reproduce in his own activities the models which are put before his eyes.

Both Freud and Durkheim have thus pointed the way to an understanding of man's social behavior, and others also could be named who have directed attention to the importance of identification. I am convinced that

* See Talcott Parsons[8] for a more detailed analysis of what he describes as the "utilitarian dilemma" and of Durkheim's solution to this dilemma.

studying the mechanisms of identification will give sociologists more answers to the problems they want to solve than any other single course of investigation could offer. But we are confronted by the rather surprising fact that many of them aren't much interested, and by the perhaps more astonishing fact that those *analysts* (or former analysts) who claim to be most sociologically or culturally oriented (Karen Horney, for instance) pay *least* attention to the process of identification. Why should this be so?

The problem seems to come down to a very basic issue: whether human nature should be regarded as inherently "good" or "bad." Are people to be seen as driven by gross sexual impulses and by wild destructiveness, or are human beings by nature beneficent, reasonable, ethical creatures? For various reasons the majority of "deviant" analysts have been unwilling to accept Freud's allegedly pessimistic view of human instincts—and the same has been true of many sociologists.

Some of the deviant analysts' criticisms of orthodox analytic theories have been, I believe, correct; many of them have sensed that there were phenomena for which an adequate explanation could not be found on the psychological level alone. Quite properly, then, these deviants tried to bring in a consideration of social and cultural processes, but they evidently could do it only at the expense of neglecting much that has been well established in psychoanalytic theory—and besides that, they weren't very good sociologists either. As Freud[8] put it in discussing the work of Adler and Jung, "they have caught a few cultural overtones from the symphony of life, but once more have failed to hear the most powerful melody of the impulses." In a word, they rejected Freudian instinct theory.

Now at the same time that some of these deviant analysts criticized Freudian theory as being "too biological, " many of them have actually, and paradoxically, come around to envisaging an ideal human being who in most significant respects *is* simply a biologically determined child of nature. This ideal person is "spontaneous" (Fromm), capable of exerting his "will" freely (Rank); able to express the inherited "archetypes" within him (Jung); his natural adaptive capacities are not "artificially" distorted by the cultural patterns and social pressures imposed upon him from without (Horney et al.); "symbolic systems" (T. Burrow) have not interfered with his total functioning as an organism; and finally he is capable of complete and uncomplicated sexual gratification (Reich). It is as if these writers said "Freud was wrong; behavior is *not* simply determined by psycho-biological processes—but we wish it were. The intolerable pressures of civilization have corrupted natural man; if all were right with the world natural man would again reign supreme; if he reigned supreme all would be right with the world." They have thus postulated, much as the utilitarians did but not at all explicitly, a kind of "natural identity of interests";

they evidently assume that if every individual were really able to seek his own biological self-fulfillment without external interference, a harmonious society would be the automatic result.

A crucial element in this point of view is the supposition that social and cultural influences are essentially external to the individual, rather than internal or *internalized*. These deviant writers assume, accordingly, that the individual is restive under the alien constraints imposed by the culture and that the latter should therefore be removed. But if they were removed, one might ask, wouldn't the primary impulses of sexuality and aggressiveness rage unchecked? No, these writers answer, because such impulses are *not* the primary ones; basically human beings are impelled by good, socially constructive motives. Leave the individual alone and he will be able to express these beneficent strivings in a healthful, and even an ethical, way. They have "proved," in this fashion, that Freudian instinct theory must be in error, and that human impulses cannot intrinsically be of such a socially disturbing nature as Freud maintained.

The deviants' point of view is in a way more optimistic than that of Freud, and hence more congenial to those of a reformist turn of mind: they believe that it *is possible* to remove the social and cultural restrictions which hamper individual development and thus avoid the problems these restrictions impose. In contrast, Freud[3] held that in view of man's instinctual makeup, the cultural process inevitably imposes problems upon humanity. But he was also more optimistic than he is sometimes given credit for being: he held that although the problems mankind confronts are unavoidable, they are not for that reason insoluble, and in *Civilization and Its Discontents* he expressed a hope that just as stresses within the individual eventually admit of a solution, so it may also be with the future of civilization.

Now what has all this paradoxical argument to do with the problem of identification? Simply this: if you believe that mankind's instinctive impulses are on the whole beneficent and ethical, and if you are content to "explain" organized social life as arising directly from these good, constructive drives, there is no need to study the process of identification. If you believe that man is inherently reasonable, all you have to do is give reason a chance. Or if you think character is irrevocably shaped by a process of conditioning, you only have to decide what kind of culture you like, and then let the culture prescribe the methods of swaddling, weaning, etc., that "fit" or "are congruent." If things go wrong, that's because there are too many "inconsistencies" or "contradictions" within the culture. Modern civilization gets us all confused. Let people fulfill themselves as individuals, keep that old devil civilization out of the way, don't make demands that go against nature, and we'll all be saved.

But if you believe that human impulses, if unmodified and unrestrained, are pretty devastating to organized social living, then you have to ponder the question of how it is that restraints do get placed upon them. How is it that human impulses become so firmly disciplined that people can have the illusion that man is *instinctively* an ethical being, or a rational being? If you think man *is* rational, then you can believe that external controls are enough to guide him in the path he should go. But if you don't assume that he is rational, it becomes necessary to look at the *internal* controls over his behavior, and wonder how they got there. Looking at the problem this way, it must be concluded that social constraints and instinctual impulses in the individual are *necessarily* opposed, and that the opposition is so fundamental that it cannot be controlled simply from the outside.* Social constraints which were originally external to the individual must somehow become internal, a part of the individual himself. It must be concluded, finally, that this process itself is a "natural" one—that it is part of man's impulsive or instinctual nature both to oppose society and (again on the basis of his instinctual makeup) to incorporate society and be incorporated by it, to be a part of a larger whole.

The way in which Durkheim arrived at this conclusion that I have just stated is, I think, of interest. Like the utilitarian theorists—and in fact, like a great many psychologists, psychiatrists and analysts, even including those who count themselves as orthodox Freudians—Durkheim started out thinking of "social facts" as something external to individuals. Usually when I hear psychiatrists talking about "social factors," or trying to grapple, generally unsuccessfully, with such a sociological concept as that of "role," there seems to be this same feeling that what is social or cultural is somehow external to the individual, though it may "influence" him in relatively unimportant ways. At most, psychiatrists seem to think that people participate in the social process with just the peripheries of their personalities.

But to return to Durkheim—his argument ran as follows. The biological organism sets limits upon the gratification of bodily needs: one can eat only so much, then the limit is reached, and one can eat no more. In that case *natural* constraint is exercised upon the satisfaction of wants by a physiological force which opposes the force of the individual's own appetites. But there are other appetites—for prestige, power, wealth, love, knowledge—upon which no "natural" limitations are placed. Now any force, Durkheim argues, which is not limited by a contrary force tends to lose itself in the infinite. And if one's goals are infinite, one can never have

* This is not to say that they are completely and in every particular antagonistic; social life is of course based on the instincts and does not merely constrain, but channels and releases them.

the feeling that any progress is being made toward their achievement. Without the discipline over his impulses that is derived through identification with his society and with its values, goals and prescribed ways of doing things, the individual would be subject to the tyranny of his own impulses; he would have no means for mastering them or even of gratifying them; he would lack emotional awareness of the social reality that does limit him; and he would be at war not only with others, but also with himself. The essential point is that when the individual does become identified with the values and norms of his society, these no longer *appear* to him as limitations to which he feels his own wishes are opposed. The individual accepts the discipline imposed upon him by his society and makes it his own, and where this inner discipline is strongest, the individual actually feels most strongly that he is acting as a free agent. The mature individual's adherence to a given rule of conduct thus does not spring from his fear that violating it will have unpleasant external consequences, but from his voluntary acceptance of it as a duty, as a moral obligation, and in fact as what he wants to do. The person who can "choose" the action which conforms to the standards he accepts, feels free in so choosing, feels that he is fulfilling himself. People who have not accepted and internalized the "opposing force" of society may act more in obedience to their impulses, but they do not feel free, and they do not feel happy—nor does their behavior contribute to the effective functioning of the society of which they are members. They have not succeeded in forming those identifications with their fellowmen, and with the values guiding the society into which they were born, which are essential for their own—and for their society's—self-realization.

Despite the criticisms that have been leveled at Freud's theory of the primal horde, it is evidently possible to discover some elements of the "historic" truth he claimed for it. These elements are not to be found in his description of the original "social contract," nor yet in the postulation that "racial memories" of this or other significant historic events are biologically inherited from past generations; rather such surviving traces of the past can themselves most convincingly be traced, as Erikson[9] has shown, to the process of identification. But at some period in the evolution of man from his pre-human ancestors there must for the first time have developed the capacity for identification with other human beings, and it is this which Freud did indeed try to describe: the loving and hostile identification of the sons with the murdered father, and of the sons with each other. We can then suppose that it was the capacity for forming this sort of emotional tie to his fellows that first made possible man's creation of society, morality, religion and art—in short, the creation of humanity—

and that this was a "historic" event of the greatest significance, from the standpoint both of sociology and of psychoanalysis.

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POETRY OF PATIENT

Foreword: Someone has defined psychiatry as the branch of medicine in which the emotions are considered to be important. Of course, recognizing thoughts and feelings is one thing; expressing them in such a way as to arouse similar or responsive thoughts and feelings in others is another thing. Poets and writers and speakers possess skill in doing the latter; unfortunately neither psychiatrists nor their patients are, as a rule, poets, writers, or speakers. When, therefore, a patient has the special gift of being able to put in words and meter certain combinations of thought and feeling which have this artistic quality of verisimilitude, there is a bilateral gain: the patient himself is benefited and those who find their feelings verbalized and (by implication) shared, are likewise benefited. Many poets make no secret of their personal suffering, but few poets write frankly from the standpoint of a patient, that is, a sick person. This takes courage as well as talent.

The following verses were written by a woman patient (A. M. S.) in middle life who had been ill for several years, but was now improving. She is resuming her normal life program again and gives her consent to this publication.

K. A. M.

LOST DREAMS

There was a quiet, woodsy stream
I went to, when a child, to dream;
The lucent water trickled by
And mirrored trees and deep blue sky.
It was a spot—so sweet, so fair—
I think I left my dreams all there.

RELEASE

Since I must ever live my life in chains
Bound always to a thing that is not I,
More terrible than sorrow's sharpest pains—
This fiery foe that I cannot defy,
Oh, death will be a blessed boon to me—
Nor heaven nor hell for me it holds—
Just infinite insensibility,
To lie in earth, serene and cold,
And knowing naught of love or hate,
Just feelingless—inanimate.

FUTILITY

There is a hurt in the sunlight's gold,
The beautiful and good are not for me—
I who must live my life, shut out
From human warmth and love and sympathy.

Cold words, disdainful looks from those
Who could give help and understanding.
Am I who have friendliness to give
Too much of them demanding?

Oh, must I live my life, only to find:
The earth—the all-embracing earth—is kind?

CONFLICT

So much of good and beauty
Is of my life a part—
I who live in heaven
With hell in my heart.

SEASONAL

Lying on earth beneath the summer sun,
Whose healing rays brought sweet oblivion
To troubled minds, sore pressed and tried—
Halcyon days so long denied—
Cloud-flecked sky of azure sheen,
Glimpsed through branches, leafy green;
There mid quiet scenes and days well spent,
My stormy heart was nearest to content.
But time moves with inevitable pace—
A hostile, hurtful world again to face,
I look at sere, brown grass and leafless bough
And dull, gray sky—it's winter, now.

MUSIC

It lifts the mind and carries it,
In temporary transcendence,
To rhythmic heights of peace and joy—
A momentary resplendence.
To troubled souls, insatiate,
A flag of truce unfurled—
Sweet harmony that modifies
An unharmonious world.

CHOICE

Face to face with a dream—
I chose the best—it would seem
To keep a dream is better far—
Dreams are better than real things are.
Through the years, illusions live—
Phantasy, incarnative.

ONENESS

The will to think as I want to think
With a mind that is all my own
To leave behind the black abyss
And the horrors that I have known—

If God there be (and I doubt it much)
Please listen to my cry:
That I may be through eternity
Only the "I" that is I.

TO MY HUSBAND

You are like solid earth beneath my feet.
You are like a rock or a tree.
In this reeling, dizzy, uncertain world
You live so changelessly.

I live in worlds you may not know
Or clearly understand;
You cannot fill my every need
Or equal my demands.

But this erratic, fickle world
Can't give us all it should—
And solid earth is requisite,
And trees and rocks are good.

ACHIEVEMENT

Acceptance of what has to be,
A muted joy in what I see
And hear and know and think and feel—
And living that again seems real.
When all these, various things I find,
Perhaps I'll call it peace of mind.

CORRELATION

The harvest moon shines, clear and bright,
How can I sleep on such a night
Of dazzling brilliance, sharp with frost—
When one counts summer days well lost.

There is a harvest time in life,
Of passing years mature and rife;
It brings to me a beauty, still and deep—
I shall not waste too much of it in sleep.

FROM PSYCHIATRY

Out of the chaos of a broken world,
Like a beacon light on a stormy sea—
Resurgent life and strength and hope
And understanding came to me.

RAPID RECOVERY FROM LONG STANDING ILLNESS

A Case Report*

By JAMES M. MOTT, Jr. M.D.†

Note: An outstanding challenge both to science and to hospital administration exists in the large number of custodial cases filling up our state and federal psychiatric hospitals. There is a long tradition of pessimism regarding the recovery of patients who have been hospitalized more than three years. This pessimistic attitude becomes reinforced by reflection from doctor to relative to patient, and the other way round. Doctors give up trying to help patients, patients give up trying to get well, relatives give up trying to help them get well. The introduction of the new spirit of optimism can sometimes reverse this vicious cycle. We could better assume that all of our patients will get well, and expect exceptions than to assume that most of them will not get well and be surprised at the exceptions. What is now the exception might conceivably become the rule if we could determine just what therapeutic leaven is needed in each particular case.

This is the philosophy of many contemporary psychiatrists, and it is contrary to the malignant pessimism of past years. In the opinion of the editors, the following case report is an eloquent example of the principle that in certain cases, at least, continued illness and continued hospitalization represent our continued failure to discover the particular need of a particular patient. For 17 years this patient was an expense to the state, and a burden to herself, her family, and her community. In the course of a few months at a total time investment by the staff of only a few hours, she made a swift and dramatic recovery. One cannot but wonder how many other patients who have been hospitalized 17 years or less might be similarly rehabilitated, if someone had the patience, the imagination, the skill or the good fortune to press the right key. Just how to find that key should be the stimulus of the most intensive research, and such a case report as this challenges our resources and our interests.

K. A. M.

The patient to be described is now a woman of seventy-two. She was admitted to the state hospital at the age of fifty-five, in July, 1932 following a homicidal attack on her husband.

She was one of three siblings born and raised on a farm. Her mother died when the patient was eight years old and she quit school to keep house for her father and siblings. When fourteen, she left home and went into domestic service. She married at the age of sixteen and had three children. Her husband died four years after this marriage. She worked as a seamstress and practical nurse for the next seven years and then married a second time. She divorced this husband after two years because he was a drunkard and abused her and her children. Within a year she married a third time and lived with this husband ten years before divorcing him. Five years later she married a fourth time, but also divorced this husband four years

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later because he was a drunkard. Then she went to care for her ailing father and nursed him for ten years until his death at the age of eighty-two. Following his death she stayed briefly with one after another of her children who were married, but was unhappy because no one understood her, and the grandchildren annoyed her and tired her out.

She married her fifth and last husband when she was fifty-two. Within four months after this marriage she wrote her children that her husband was involved in a whiskey and dope-peddling gang, that he had put formaldehyde in her milk and on her toothbrush, and that he had castrated all the roosters and was poisoning the hens. She refused to leave her husband, as the family physician advised her to, because she considered him mentally ill and felt he needed someone to look after him. A year prior to her admission to the hospital, she was seen by a psychiatrist at her children's insistence, and he advised immediate hospitalization stating that she was dangerously mentally ill. The husband refused to hospitalize her until the homicidal attempt convinced him she required such care.

At the time of admission in July, 1932, the fifty-five year old patient readily admitted attacking her husband stating that he deserved it because of his mistreatment of her. She was quiet and went willingly to the ward. She appeared to be clean and neat. Entries on the patient's record were as follows:

July, 1933—"The patient is mentally better at this time than at the time she was admitted to the hospital, but is still delusional."

May, 1936—"The patient is delusional, but has not expressed many of her former delusions during the past two months. She works willingly in the sewing room and is quiet and cooperative on the ward. She has shown a tendency to injure others and should be observed for a much longer period of time before a parole is considered."

February, 1938—"She works in the sewing room. At times she feels she has been poisoned. She is pleasant with other patients most of the time. She seems quite preoccupied with ideas of "Unity." She has shown many delusions of a paranoid nature and has periods of mild excitement."

November, 1939—"The patient frequently becomes disturbed, but when quiet, is pleasant, cooperative, and helpful in the sewing room. She is delusional and paranoid. She believes that the linen is medicated by someone plotting against her and it causes her skin to itch."

November, 1940—"There has been no essential change in this patient since the last report of two years ago except that she seems less delusional and in somewhat better physical condition. She goes daily to the sewing room and is expert with her work."

July, 1941—"This patient was examined today by a medical board consisting of three psychiatrists because of divorce proceedings brought by her husband. She was unanimously adjudged incurably insane."

June, 1942—"The patient is adjusting only fairly well. She has numerous physical complaints all without actual physical basis. A short while ago when a fortune teller told her she would leave the hospital within a week, she threatened dire consequences if such did not occur. She is somewhat of a trouble maker and likes to explain to visiting relatives the ins and outs of hospital treatment."

My first contact with the patient was in March, 1949* when I began making rounds on her ward. She was an amazingly spry woman for seventy-two years of age. Although very likeable, she was such a disturbance and nuisance on the ward that a number of patients and aides wanted her transferred. She felt that a gang of criminals were plotting to prevent her leaving the hospital, and that these public enemies were also after her children. Among the plotters against her she included, from time to time, various aides, supervisors and doctors. She said that her son came from his home (a round trip of about 3,000 miles) every day to get her out of the hospital. She would see him behind the hospital, would shout out the window to him, and frequently at night would be at the window carrying on a very loud conversation with her son who also talked to her. This delusional pattern of behavior continued for about three months.

When I visited her ward, the patient would meet me at the door and begin a harangue in a stereotyped manner about being paroled to her son or daughter. If encouraged by the slightest attention, she would go into a detailed explanation of all the subterfuge that would be necessary to prevent interception by the ever-alert criminals. This insistent badgering continued throughout my rounds on that ward.

She told me that a doctor had told her that her children had not been to the hospital for four or five years (as was true), that they were not going to come, that he would not let her see them if they did come, that she might as well make up her mind she was going to be in the hospital the rest of her life, and to settle down and make as happy an adjustment as she could. An aide had attempted, according to her, to point out the impossibility or improbabilty of her son making a 3,000-mile trip every day. She had been asked to accept hospitalization, she said, so that her son would not have to make this daily trip which interfered with his life and his work. In spite of these delusions, the patient was an excellent worker on the ward and was considerate of other patients particularly when they had some intercurrent physical illness. Also, she could be trusted to run errands to the hospital store, unaccompanied.

During my first three months at the hospital, there were two days when I did not make rounds, and apparently as a result of the previous frequent change of doctors, the rumor started that I would no longer make rounds there. When I returned, the patient greeted me at the door, spent about ten minutes explaining how she had heard that I had quit and how terrible that had made them all feel, how much they liked me, etc., and tearfully asked

* At this time, a new staff of physicians came to the hospital and the regimen of patient care was changed to one of active treatment. This was the result of increased state appropriations and the institution of teaching and training facilities in the hospital.

for reassurance that I would continue to make rounds. After being reassured, she abruptly stopped this conversation and lapsed back into haranguing me about not letting her out, not letting her son come in to see her, insisted that her son was outside the building, that she had seen him that afternoon, and in general carried on as she had previously.

Soon after this, she began to point out her son or her son's friend to me and we made a number of trips off the ward to talk to such individuals who, of course, turned out to be employees or male patients. Together we would introduce ourselves to the person, find out who he was, where he stayed, and then go back to the ward without any particular comment from me. The patient at times accepted the fact that the man was not her son, but at other times she explained that he really was her son's friend, but because the kidnappers were near by he was unable to reveal his true identity.

The patient's relatives had meanwhile been contacted by social service workers and were greatly opposed to any discharge or parole plan. Their visits with the patient during the first five or six years of hospitalization had been unhappy ones with her haranguing them, as she did the personnel of the ward, to sign her parole. They felt that she was dangerous since she had attempted to kill her husband, and did not want her in their home.

The patient's ability to dissimulate was frequently demonstrated. She could carry on a rational conversation for as long as five minutes at times, but the psychotic material would inevitably break through. The affect accompanying her delusional material was appropriate in that she was quite fearful of the criminals, tearful, and demanded her release so that she might relieve herself and her family of the torture and torment of being separated.

Five months after my first contact with the patient, I began discussing with her bit by bit some reality factors involved in her discharge. The plan was for her to remain in Topeka on parole from the hospital for an indefinite trial period and for her to pay weekly visits to the hospital at which time she and I would talk over her problems. I pointed out, and she readily agreed, that most people considered many of her comments and much of her behavior as "crazy" primarily because they didn't understand her. I repeatedly asked her not to talk of the criminals to anyone but me. She gradually complied.

Two weeks later while carrying on her usual conversation with her son at night from the window, she told him she was making plans to leave the hospital, would be in Topeka for awhile before she could come to his home, and advised him to stop making these long trips to the hospital to sign her parole as it was no longer necessary. The patient gradually ceased being hallucinated, refrained remarkably well from discussing her delusional ideas on the ward, but continued to talk about them in discussions with

me which were limited to one one-half hour appointment per week. She began going down town, at first with a companion because she was a bit apprehensive about going alone not having been out of the hospital for seventeen years. It was interesting that little things like traffic lights were confusing to her; she was not sure what the red and green meant, and the amount of traffic and number of cars both amazed and confused her at first.

The patient displayed excellent judgment when she began to apply for jobs that fall. Although she answered, by telephone, advertisements of people who wanted a companion housekeeper, she always made an appointment to see them. She obtained a job early in November in this manner. After having talked with an elderly woman and this woman's son about her qualifications for the job, about salary, the room she would live in, and such matters, she told them that she had been a patient in the state hospital. She talked to them about the changes that had occurred in the hospital, and of the progressive way it was now being operated with the result that a number of patients who had been well for quite some time, of whom she was one, were able to leave to look for work. Feeling that they would wonder whether a person who had been in a state hospital was dangerous or in any way peculiar, she informed them she was doing this with the full knowledge and permission of the doctor, and referred them to me and to the social worker so that they might ask questions. This family got in touch with me, described the interview essentially as the patient had told it, said they were favorably impressed with her, and if we felt she could do the job, they wanted to hire her.

The patient left the hospital on parole in October 1949, and returned to the hospital once each week for the next month. From interviews with her, from contact with the family, and from the reports of a doctor taking care of the woman for whom she worked, she appeared to be making an excellent adjustment and doing a superb job as a practical nurse and companion housekeeper. She continued to plan to live with her son when she was released and she requested release during each interview with me. Gradually the delusional system disappeared. The patient was able to accept counsel in the nature of discussions about children's feelings about parents, spouses' feelings about mothers-in-law, etc. She became active in Eastern Star of which she had been a member. She enjoyed visiting with three or four friends of hers in town and also went regularly to the library.

The interval between interviews was lengthened to two weeks, then to three weeks, and in January, 1950, the patient was discharged. At this time she accepted the fact that her son was unable to have her in his home, did not even want her to visit, but that he would visit her during his summer vacation. She verbalized her feeling that he and his wife apparently felt that she wanted to make her home with them or be dependent on them financially, and that it would take time for them to learn better.

In February, the woman whom she was nursing died of cardiac failure. Soon afterward the patient made an appointment with me. She came proudly to show me the four excellent recommendations given her by the doctor and relatives of the woman she had been caring for. In the following week, she had five offers of jobs each of which she was investigating to see which she wanted. Two of the local doctors asked her to take cases for them. Three friends and the son of the woman she cared for asked her to feel free to move in and live with them until she got another job. Her daughter and son-in-law insisted that she come and make her home with them.

At present this seventy-two year old woman is working satisfactorily on another case. She shows no evidence of psychosis and indeed seems to be better adjusted characterologically than she was before the illness which led to her hospitalization. The patient has been out of the hospital only six months, and this certainly is not long enough to consider the patient "cured," but in view of seventeen years of continuous closed ward hospital care, it stimulates inquiry into a number of concepts which have been accepted as true for the most part.

One of these concepts which I think warrants examination, based not only on this case but also on my contact with 500 state hospital female patients who have been hospitalized an average of roughly fifteen years, is that of deterioration in schizophrenics. In staff conferences when shock therapies or psychosurgery is considered, one of the "positive indications" frequently postulated is the probability of deterioration. How often is shock or lobotomy recommended in cases where it is not really indicated, from our knowledge of response to it, on the basis that if we don't do something, "the patient will deteriorate"? What really is deterioration? How does it differ from regression? Is it irreversible? And finally, how frequently does it occur in chronic, hospitalized, functional psychotics?

I suggest that we record and examine the many recoveries of chronic psychotic patients, whether the recovery appears to be the result of psychotherapy or a so-called spontaneous remission, to determine 1) the factors in the patient which make reversibility of a chronic psychosis possible and 2) the factors outside the patient which act as catalytic agents on the positive reversible potentialities in the patient

We should remember that this patient, along with hundreds or thousands of others, was considered and labeled incurably insane in the years past and as a result was isolated to such a degree that she knew nothing of stop lights. If we are to discharge our responsibilities to our patients we must not repeat these mistakes—we must encourage and stimulate contact with the outside world of reality, its progress and changes. Even though they seem incurable, we must consider all our patients potentially reversible and, at the very least, not allow such isolation as occurred in this patient.

BOOK NOTICES

Blakiston's New Gould Medical Dictionary. HAROLD W. JONES, NORMAND L. HOERR, and ARTHUR OSOL, eds. Price $8.50. Pp. 1294. Philadelphia, The Blakiston Co., 1949.

A staff of 100 physicians, including several psychiatrists prepared copy for this edition. It is well printed and well illustrated. On the practical side it is good; on the theoretical side, it is weak. For example, disease is defined as an illness or sickness; illness is defined as sickness or disease (plus); sickness is defined as disease or the condition of being unwell; unwell is defined as ill or sick. Sample selections of psychiatric terms proved similarly disappointing. (K. A. M.)

Projective Techniques. By JOHN EDLERKIN BELL. Price $4.50. Pp. 533. New York, Longmans, Green and Co., 1948.

Clinical psychologists now have for the first time a broad survey of the projective techniques. Bell has digested almost everything that has been written about projective tests of any significance. In a number of handy tables, he has summarized in easily surveyable form the principal methods of interpreting most of the tests and whatever diagnostic indications have been reported for each. The book will probably stimulate both practice and research with projective methods. (Robert R. Holt, Ph.D.)

Marriage. By ROBERT A. HARPER. Price $2.75. Pp. 308. New York, Appleton-Century-Crofts, Inc., 1949.

This factual, simple book on marriage is a little professorial in style but very readable. The content is based upon recognized knowledge from other sources. I find nothing particularly new nor unique in the organization of the material. (Robert G. Foster, Ph.D.)

Encyclopedia of Criminology. By VERNON C. BRANHAM and SAMUEL B. KUTASH. Price $12.00. Pp. 527. New York, Philosophical Library, Inc., 1949.

The contributions of sixty-one authors bring together in this book many divergent points of view in the field of criminology. Basic topics are handled concisely, are alphabetically arranged, and have bibliographies, making this an excellent source book. Seeing the beginning application of present personality theories to the existing legal and sociological framework of understanding and handling of criminal behavior is of special interest to the psychiatrist. (Jack A. Dunagin, M.D.)

The Universe and Dr. Einstein. By LINCOLN BARNETT. Price $2.75. Pp. 127. New York, William Sloane Associates, 1948.

As Albert Einstein says of this book in the foreword, "The main ideas of the theory of relativity are extremely well presented (and) the present state of our knowledge in physics is aptly characterized. The modern psychiatrist who attempts any theoretical formulations should have at least an elementary knowledge of the quantum theory and other factors of modern physics and mathematics. This is a good place to get it."

Some good incidental quotes: "Common sense is actually nothing more than a deposit of prejudices laid down in the mind prior to the age of eighteen. Every new idea one encounters in later years must combat this

accretior of 'self-evident' concepts" (ascribed to Albert Einstein, p. 52). "Sensitive cameras can detect the glimmer of island universes 500 million light years away . . . that began their journey at a period of terrestrial time when the first vertebrates were starting to crawl. . . . These huge outer systems are hurtling into limbo (away from us) at incredible velocities ranging up to 35,000 miles a second, or more precisely, they *were* receding from us 500 million years ago. Where they are 'now,' or whether they even exist 'now,' no one can say" (p. 66). "This functional harmony of nature Berkeley, Descartes, and Spinoza attributed to God. Modern physicists who prefer to solve their problems without recourse to God (although this seems to become more difficult all the time) emphasize that nature mysteriously operates on mathematical principles." (K. A. M.)

Critical Studies in Neurology. By F. M. R. WALSHE. Price $4.50. Pp. 255. Baltimore, Williams & Wilkins, 1949.

Problems of cutaneous sensation, and the anatomy and physiology of motor movements are dealt with in this collection of reprints of articles published in *Brain*. The objective is not to add any contribution of data but to criticize any concepts which appear to contradict the author's philosophy that a particular phenomenon of sensibility or motor action is the product of anything but the diffuse response and integration of the nervous system. This attitude leads the author into attacking the well established concepts and failing to include new significant data. (L. Berlin, M.D.)

Adolescent Character and Personality. By ROBERT J. HAVIGHURST and HILDA TABA. Price $4.00. Pp. 315. New York, John Wiley & Sons, Inc., 1949.

Considering character as more or less synonymous with "moral reputation," the authors attempt to trace the influence upon it of such factors as social class, school, church, "personal-social adjustment," etc. One chapter is devoted to a presentation of steps which might be undertaken within a community to help develop better "moral character." In general the book is instructive from the methodological viewpoint but would be of greater value perhaps to educators than to clinicians. (Richard Siegal)

Mirror for Man. By CLYDE KLUCKHOHN. Price $3.75. Pp. 313. New York, McGraw-Hill Book Co. Inc., 1949.

Taking up one of the most vital problems of this century—whether world order can be achieved by the domination of one or more nations—Kluckhohn points out the necessity of understanding different cultures if lasting peace is to be achieved. This is an important and revealing contribution to our scientific literature for the layman. The application of anthropology to modern life in our own country is especially valuable. (Robert G. Foster, Ph.D.)

Sexual Disorders in the Male, 3rd ed. By KENNETH WALKER and ERIC B. STRAUSS. Price $3.50. Pp. 260. Baltimore, Williams & Wilkins Co., 1948.

The spirit of this volume is precisely phrased in the preface to it: "It may be said, perhaps, that even more emphasis has been laid on the psychic as opposed to the somatic aspects of male sexual disorders, especially

so far as treatment is concerned. To offset this, however, a brief description of the mechanotherapy of impotence has been added." The book is seriously marred in its presentation of therapy. The inclusion of such remedies as galvanism and vasoligation for the treatment of nocturnal emissions causes one to question the real "psychosomatic" orientation of the volume. (John R. Adams, M.D.)

The Driving Forces of Human Nature. By THOMAS VERNER MOORE, M.D. Price $6.50. Pp. 461. New York, Grune & Stratton, 1948.

The author attempts to correlate the various schools of psychological thought and to synthesize them into an easily understandable text suitable for a beginning psychiatric resident or someone of equivalent status. The book has a strong orientation in religion and philosophy. There are a number of case presentations which include good reports of the psychotherapeutic approach which seems to be of a very effective supportive type. (Murray Bowen, M.D.)

Protecting Our Children from Criminal Careers. By JOHN R. ELLINGSTON. Price $5.00. Pp. 374. New York, Prentice-Hall, Inc., 1948.

One of the best things the American Law Institute ever did was to draw up a pattern for the administration of criminal justice for youthful offenders. This was begun in 1938 and made public in 1940. The following year California enacted legislation incorporating the principles and procedures of the model act, and other progressive states have followed suit. The author of this book, a lawyer by training, has devoted himself to the project for seven years and he presents the spirit, the purpose, and the rationale of a civilized and scientific plan for just what the title describes. (K. A. M.)

Education Through Art. By HERBERT READ. Price $5.50. Pp. 320. New York, Pantheon Books, 1945.

Herbert Read is concerned with the educative process as a whole, particularly as it applies to children. His thesis is that education of schoolchildren is a matter of growth of self-expression in relation to society, that reason and feeling must be permitted to remain indissolubly linked and not driven apart by our emphasis on logic, that didactic instruction is largely a waste of time and children, and that a teacher's proper job is occasionally to raise an eyebrow or point a finger. This laudable theme is developed with erudition and persuasiveness, but is somewhat marred by the long divagation into the field of psychological types. (Donald J. Watterson, M.D.)

Experimental Psychology. By BENTON J. UNDERWOOD. Price $4.50. Pp. 638. New York, Appleton-Century-Crofts, Inc., 1949.

Experimental psychology used to deal with the precise measurement of relatively unimportant psychological processes. Gradually more important problems have become recognized by experimental psychologists. This book with its chapters on motivation, frustration, and conflict and its elimination of some of the more traditional topics is an example of the trend toward broadening the field. The author writes simply and clearly and has ably achieved his objective. (Robert C. Challman, Ph.D.)

Studies in Psychosomatic Medicine. By FRANZ ALEXANDER and THOMAS MORTON FRENCH. Price $7.50. Pp. 568. New York, The Ronald Press Co., 1948.

This book is a "collection of papers based upon the psychoanalytic study of patients suffering from chronic disturbances of the vegetative organs, written by the staff of the Chicago Institute of Psychoanalysis during the past 16 years." Its aim is to present comprehensive information concerning the "psychosomatic" era of medicine. The papers are of uneven merit. Perhaps a future edition containing an even more critical selection would make this compilation truly representative of the outstanding accomplishments of the Chicago Institute of Psychoanalysis in this field. (Sidney Rubin, M.D.)

Social Medicine: Its Derivations and Objectives. IAGO GALDSTON, ed. Price $2.75. Pp. 294. New York, The Commonwealth Fund, 1949.

This book contains the proceedings of an Institute on Social Medicine held as part of the Centennial Celebration of the New York Academy of Medicine. Social medicine, not to be confused with socialized medicine, is set forth as a nascent, distinctive discipline, rooted in clinical and preventive medicine, but drawing upon and integrating the social and psychological sciences. (Beatrice A. Gundle)

The Psychology of Personal Adjustment, 2nd ed. By FRED MCKINNEY. Price $6.00. Pp. 752. New York, John Wiley & Sons, Inc., 1949.

This book is more like a popular treatise on emotional problems than the author's designation of it as, "a basic psychological text which frankly attacks the problems of the student." Schedules and check-lists are offered as the major aid to unhappy, unpopular college students. The book ends with a list of "mental hygiene precepts," the last of which is, "Develop your *philosophy;* know where you stand and adjust to the conditions you must meet." (Arthur L. Kobler)

The Skin Problem Facing Young Men and Women. By HERBERT LAWRENCE, M.D. Pp. 70. San Francisco, Timely Publications, 1948.

The author has written authoritatively for those adolescents who are suffering from acne. In a simple and understanding manner, the facts and misconceptions regarding acne are discussed and clarified. Emotional problems and their relation to acne are handled very well, and the final chapter, "A Message for Parents" rounds out the picture in a meaningful way. Dermatologists could readily combine medical care and psychotherapy by following the author's methods of approach to adolescents. Youngsters suffering from acne need this excellent pamphlet. (Irving Kartus, M.D.)

Human Growth. By LESTER A. BECK. Price $2.00. Pp. 124. New York, Harcourt Brace and Company, 1949.

This book and the corresponding film by the same title have been the subject of much national discussion. Reproduction is presented as a factor in growth and development. The text is simple, clear, precise and accurate. The illustrations, while diagrammatic, are superb. (K. A. M.)

Introduction to Group-Analytic Psychotherapy. By S. H. FOULKES, M.D. Pp. 181. London, William Heinemann Medical Books, Ltd., 1948.

The reviewer takes exception to the word "analytic" in the book's title. The method described is good, but its connection with analysis is tenuous. Considerable attention is given to details, while only hints are given as to the basic psychological approach of the leader. The main weaknesses of the book are, confusing verbatim accounts of sessions which often do not seem to prove the point the author was trying to make, the errors in typography, and the intrusion of testimonials from patients. (V. W. Bikales, M.D.)

The Frontal Lobes. Proceedings of the Association for Research in Nervous and Mental Disease, Vol. XXVII. Price $12.50. Pp. 901. Baltimore, Williams & Wilkins Co., 1948.

Reports on the anatomy, physiology, biology and autonomic nervous system functions of the frontal lobe, as well as important contributions on psychosurgery are contained in these proceedings. Ten papers are about the neurologic, psychologic and psychiatric aspects of lobotomy. The efficacy of lobotomy for improved adaptation to intractable pain is reported from a number of sources, the initial Montreal group report on the lack of benefit from several variations of gyrectomy (topectomy) is presented, and the Connecticut cooperative group observations on 200 lobotomies for mental illness are summarized in tabular form. The general tenor of a number of comparative psychological test reports on patients in good contact with reality pre-operatively is to the effect that significant intellectual deficit does occur following lobotomy. (D. B. Foster, M.D.)

Atlas of Neuropathology. By WILLIAM BLACKWOOD, T. C. DODDS, and J. C. SOMMERVILLE. Price $9.00. Pp. 199. Baltimore, Williams & Wilkins, 1949.

This volume consists of a group of illustrations to show the significant changes in the major organic diseases of the nervous system. There are brief explanatory notes accompanying the photographs. Some of the demonstrations are excellent but others fail to yield any helpful information. There are some useful diagrams to correlate the pathology with the clinical symptomatology. (L. Berlin, M.D.)

Adolescent Phantasy. By PERCIVAL M. SYMONDS. Price $6.00. Pp. 397. New York, Columbia University Press, 1949.

This study of a special Thematic Apperception Test of the author's own devising, which was given to a series of groups of adolescents in New York should interest the clinical psychologist. For reasons that the author did not make clear, he found it necessary to prepare a complete new set of pictures. Detailed analyses of the results of administering this test to 40 pupils are given, plus several complete special studies. The pictures which are given in an appendix of the book are in general rather morose, gloomy, tragic in mood and seem to lack the variability and flexibility seen in the pictures used in the familiar Murray Thematic Apperception Test. (John A. Grimshaw, M.D.)

Patologia Psicosomatica. Compiled by ARNALDO RASCOVSKY. Pp. 786. Buenos Aires, Argentine Psychoanalytic Association, 1948.

The authors, nearly all members of the Buenos Aires Psychoanalytic Institute, acquaint one with the intensive work being done in psychoso-

matic medicine in South America through this collection. The unity is carefully maintained and the extensive and complete bibliography is difficult to match by books on the subject written in Spanish or English. An English translation would be most valuable. (Alfredo Namnum, M.D.)

Nutrition & the Soil. By LIONEL JAMES PICTON. Price $4.00. Pp. 374. New York, The Devin-Adair Co., 1949.

This is an enthusiastic and naively uncritical exhortation concerning various food fads. It is filled with examples of post hoc, ergo propter hoc reasoning, such as attributing Britain's declining birth rate to the introduction of wheat milling in 1872. Adding to its entertainment value are numerous instances of non sequitur, such as the herring being an energetic fish is therefore a superior food fish to the lazy sole. (Samuel Zelman, M.D.)

Childhood and After. By SUSAN ISAACS. Price $4.50. Pp. 245. New York, International Universities Press, 1949.

This is a group of previously unpublished papers on analytical observations of infants and children made during the last twenty years. Melanie Klein's observations are freely quoted. A familiarity with child analysis and its literature is needed to understand some of the material presented. A more comprehensive bibliography is needed. (Ralph W. Coltharp, M.D.)

Psychosomatic Medicine, 2nd. ed. By EDWARD WEISS and O. SPURGEON ENGLISH. Price $9.50. Pp. 803. Philadelphia, W. B. Saunders, 1949.

This second edition includes practically all the excellent features of the first. The contents have been very wisely recast into two parts, the first entitled Generalized Aspects of Psychosomatic Medicine, and the second, Special Applications to General Medicine and the Specialties. Much careful rewriting has gone into this new edition and some valuable new material has been added. The major appeal of this (by now) standard text-book is still to the general practitioner, internist, and beginning psychotherapist. For these groups it is an extremely valuable compilation and is a worthy addition to the working library. (Sidney Rubin, M.D.)

Psychodiagnosis: An Introduction to Tests in the Clinical Practice of Psychodynamics. By SAUL ROSENZWEIG. Price $5.00. Pp. 380. New York, Grune & Stratton, Inc., 1949.

This is a valuable introduction to and survey of the field of diagnostic testing. The reader is given some of this eminent clinician's views on the function of diagnostic tests, the scope of their contribution to the full understanding of the patient and some inkling of the process by which the psychologist arrives at his diagnostic conclusions. In no sense a manual of testing procedures, the book covers tests of intelligence, of intellectual deviation, of aptitudes, of personality (both inventories and projective techniques) and concludes with a number of interesting case studies. (Richard S. Siegal)

Rehabilitation of the Handicapped. By MAYA RIVIERE. A bibliography, 1940–1946. Price $10.00. Two vols. New York, National Council on Rehabilitation, 1949.

This is a bibliography of 5000 references dealing broadly with the subject of rehabilitation. Many of the references are briefly abstracted and there is an excellent author and subject index. There is also a supplementary list of publishers, films, film catalogs and film sources. There are many references to mental health, mental hygiene, psychiatric rehabilitation. (W. C. M.)

Stranger in the Land. By WARD THOMAS. Price $3.50. Pp. 373. Boston, Houghton Mifflin Co., 1949.

The protagonist, a male homosexual highschool teacher, is caught up in a vicious New England "witch hunt" designed to rid a small town of "perversity." Concurrently blackmailed by his former paramour, a young psychopath, he is forced into the dilemma of suicide or murder. In avoiding cliches, the author has fallen into awkward similes. A sympathetic and sensitive book, it is deprived of power by excessive length. (A. M. Kasper, M.D.)

A Miniature Textbook of Feeblemindedness. By LEO KANNER. Price $1.25. Pp. 33. New York, Child Care Publications, 1949.

This monograph presents an excellent summary of the past and present concepts in the field of mental deficiency. The factors to be considered in the further study of intellectual inadequacy are reviewed. The author then presents his own suggestion for a practical grouping of intellectual defectives, and explains his use of a "personal profile" to aid in the study and guidance of individual patients. Workers who are interested in the study of "feeblemindedness" will feel indebted to Dr. Kanner for this interesting and stimulating monograph. (F. Carter Newsom, M.D.)

Geriatric Medicine, 2nd. ed. EDWARD J. STIEGLITZ, ed. Price $12.00. Pp. 773. Philadelphia, W. B. Saunders Co., 1949.

This second edition is a well documented and well organized volume. The newer philosophical aspects of gerontology are presented very clearly by the author himself in the first two chapters and this atmosphere permeates the entire volume. In my opinion, every student of medicine should have this classic in his library. (Rudolph Chess, M.D.)

Applied Psychoanalysis. By FELIX DEUTSCH. Price $3.75. Pp. 244. New York, Grune & Stratton, 1949.

This little volume deals with four topics which were explored at the Psychiatry Clinic of Boston during the war years. The chief of these topics the author calls goal-limited adjustment, or sector psychotherapy. Could he not be induced to enrich our understanding of this brief species of brief psychotherapy in a more elaborate, and perhaps leisurely exposition? Possibly we have a gold mine here, but this present volume is only the rumor of it. (Donald J. Watterson, M.D.)

Your Child Makes Sense. By EDITH BUXBAUM. Price $3.25. Pp. 204. New York, International Universities Press, 1949.

Doctor Buxbaum has presented in this easily read book clear instruction, elucidation and guidance for parents attempting to understand their

children's thinking and behavior. It is written in non-technical language without sacrificing accuracy of content. All significant aspects of physical and psychosexual development are considered and it can be recommended to parents. (Vernon A. Stehman, M.D.)

Practical Lessons in Psychiatry. By JOSEPH L. FETTERMAN. Price $5.75. Pp. 342. Springfield, Ill., Charles C. Thomas, 1949.

The author deals chiefly with the more practical aspects of the recognition and treatment of the common neuropsychiatric disorders. These are effectively presented in an interesting, readable style with many excerpts from illustrative case histories. The book was written for and is highly recommended to general practitioners, psychologists, social workers, nurses, and other personnel who help in treating the mentally ill. (Henry Lihn, M.D.)

The Invert: and his Social Adjustment, 2nd ed. By ANOMALY. Pp. 289. Baltimore, Williams & Wilkins, 1948.

This book means to explain the facts concerning homosexuality and to prove that homosexuals may lead relatively gratifying lives. However, its facts and conclusions are difficult to accept. The author's intent to reassure anxious homosexual adolescents is well-meaning but bound to fail. On the other hand, homosexuals who have no conflict over their homosexuality do not need this book. It may be an interesting autobiographical sketch but, aside from this, it has little to recommend it. (Irving Kartus, M.D.)

The Basic Neurosis. By EDMUND BERGLER, M.D. Price $5.00. Pp. 303. New York, Grune & Stratton, Inc., 1949.

This is a carelessly written, poorly organized book. It is also an irritating book. If it were not also so thought-provoking, so stimulating in its theoretical and clinical observations, it would be a pleasure to damn it. As it is, Dr. Bergler's discussion of oral regression as the nuclear characteristic of neurosis and its consequences in psychic masochism compels the most thoughtful attention. The section on "The Underestimated Superego" contains many valuable technical suggestions as well as theoretical formulations. And the presentation of "Twenty-Seven Clinical Pictures of Oral Regression," a major section of the book, brings together a wealth of clinical data on orality, pseudo-aggression, and masochism. (Milton Wexler, Ph.D.)

How to Conquer Your Handicaps. By MARIE BEYNON RAY. Price $3.00. Pp. 336. New York, Bobbs-Merrill Co., 1948.

This book is purportedly written for the lay public as a social popularization of psychiatry. Its basic premise is to prove in a superficial way that the Adlerian Theory of the inferiority complex is the only basis for understanding people, their life adjustment and their problems. The author makes the sweeping statement that everyone has a defect and that their life adjustments and success or failure can be completely explained as a simple reaction to this defect, which is the basis of their inferiority complex. Even for general lay readers the book has no value and the reviewer takes exception to the derisive remarks about analysts, analytic theory, and modern psychiatric concepts. (Harry H. Wagenheim, M.D.)

Psychosocial Medicine: A Study of the Sick Society. By JAMES L. HALLIDAY, M.D. Price $3.50. Pp. 277. New York, W. W. Norton & Company, Inc., 1948.

Doctor Halliday courageously attacks the chaos of the field suggested by the title. He attempts to establish the basic concepts and the logical structure which must precede attempts to apply what is known about the illnesses of individual man to the problems of groups and societies. Being a poet and playwright (as well as one trained in logic, rhetoric and grammar) he makes imaginative excursions into example. He is further equipped for this task with the determination born of years of what he calls, "a dismal job," namely, that of examining workers applying for sickness benefits in Scotland. The book is almost a manifesto and, if the impulse toward captious attack on minor points can be stifled, one is led out of one's "scientific" cave. This is the line of thought which in all probability we will follow eventually, though we may find other formulations. (Bill Lewis, M.D.)

Modern Clinical Psychology. By T. W. RICHARDS. Price $3.50. Pp. 331. New York, McGraw-Hill Book Co., 1948.

With an eclectic blend of smatterings of mental hygiene, abnormal psychology, and technical procedures for investigating the psychology of the individual, the author attempts to describe the field of clinical psychology. The product is organized in a framework of theoretical speculation on the dimensions of psychopathological reactions. Primarily addressed to the college junior taking his first course in an applied field, it wisely stresses basic orientation. As an introductory text it presents many provocative ideas for class discussion. (Bernard Steinzor, Ph.D.)

Killers of the Dream. By LILLIAN SMITH. Price $3.00. Pp. 256. New York, W. W. Norton & Co., Inc., 1949.

In a patronizing review, *Time* called this book a "Freudianized tract against racial segregation." If this is interpreted to mean that the author describes and traces to its origins with great intuitive penetration the unconscious and conscious sense of guilt which all of us feel regarding our continuing crime against colored Americans, the description is correct, though inadequate. It is an intense, insistent, eloquent, and disturbing document. (K. A. M.)

Some Aspects of Hostility in Young Children. By ANNELIESE FRIEDSAM KORNER. Price $3.50. Pp. 194. New York, Grune & Stratton, 1949.

In comparing the hostility of twenty preschool children in play and in real-life, the author makes judicious qualitative as well as quantitative examination of the data, and her use of a small sample, thoroughly investigated, seems justified. No direct observation was made of the child with other children, or with his parents. The expressed hostility of either child or parent was in itself found not diagnostic of adjustment and it is clear that a highly individualized theory of personality is needed to explore the dynamics of hostility. The contention that the "frustration-aggression" type of hypothesis is often over-simplified, is well-supported. There is striking confirmation for the rationale concerning movement responses in the Rorschach test, and the relation between Verbal and Performance scales in the Wechsler-Bellevue. (Sylvia Brody)